AUTHORIZATION TO RELEASE INFORMATION

Patient's Name: _____

Patient's Address: _____

City, State, Zip: _____

Date of Birth: _____ Telephone No: _____ SSN: _____

Digestive Care & Management
6043 Shallowford Rd Suite 113
Chattanooga, TN 37421
Office 423-698-1791 Fax 423-803-2792

Release of information from D.C.M, L.L.C

_____ I authorize D.C.M. to release copies of my records as listed below. The information should be sent to:

_____
Name of Physician, Institution, Self, Etc.

_____
Address

_____
City, State, Zip

_____ _____
Telephone Number Fax Number

Release of information to D.C.M., L.L.C.

_____ I authorize the release of information from:

_____
Name of Physician, Institution, Etc.

_____
Address

_____
City, State, Zip

Please send information requested to:
Digestive Care and Management, LLC
Telephone: 423-698-1791
Fax: 423-803-2792

Please note that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by D.C.M.

DATES OF TREATMENT (which dates of treatment do you need records for?)

Dates: _____

The information that is to be released should be detailed to specific dates of service, treatment, etc. A meaningful description of the information to be disclosed should be proved.

Information to be Released

_____ Discharge Summary
_____ History & Physical
_____ Operative Report
_____ X-Ray
_____ Clinic Visits
_____ ER Records
_____ EKG
_____ Laboratory
_____ Physician Orders
_____ Other: _____
☐ HIV Results _____ (Initials)
☐ Mental Health Records _____ (Initials)

Purpose of Release

_____ Attorney
_____ Social Security
_____ Continuation of Care
_____ Worker's Comp.
_____ Disability
_____ Insurance
_____ Deposition
_____ Billing
Other (Please Specify Below)
_____

I have read, or have had read to me, the above statements, and understand them as they apply to me. I further understand that I may revoke this authorization at any time, except to the extent that action has already been taken in accord with this authorization. Revocation by the patient or patient's legal representative is allowable only in the event that release of information has not already occurred. Specific exceptions to revoke an authorization exist, as detailed by federal law, such as:

- Digestive Care & Management has taken action in reliance on the authorization, or
- The authorization was obtained as a condition of obtaining insurance coverage, whereby another law provides the insurer with the right to contest a claim under the policy.

In order to revoke an authorization, a written document stating the intent of the patient to revoke such authorization must be either presented in person or delivered by certified mail to the Privacy Officer of D.C.M. This revocation document must contain the signature of the patient or patient's legal representative, and that signature must be formally certified by a Notary Public. I understand that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining this authorization.

_____ _____
Signature of Patient or Appropriate Legal Representative Date

(If a personal representative of the individual signs the authorization, a description of such representative's authority to act on behalf of the individual must be provided.

_____ Photo ID was provided _____Yes _____ No
Relationship if Not Patient

(If no, the form of identification must be so sated and a copy provided with the authorization. In order to be valid, the signature on the authorization must be after the date of service that is being requested for release).

_____ _____
Witness Date